ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Employment Administration

FAX

ESTE DOCUMENTO AFECTA SU ELEGIBILIDAD PARA SEGURO POR DESEMPLEO. SI USTED NO LEE INGLES, COMUNIQUESE CON LOS CENTROS PARA LLAMADAS A LOS NUMBEROS INDICADOS ABAJO. SI CORRIENTEMENTE TIENE TRABAJO DE TIEMPO COMPLETO, DESCUIDE ESTA FORMA.

Date Mailed:

Claim Number:

You have been scheduled for an eligibility review by Employment Administration staff. Your eligibility for Unemployment Insurance Benefits will be reviewed based on the information you provide, and our staff will determine what services the department can provide to assist you in your reemployment efforts. If you have any questions, call **602-364-2722** if you live in the Phoenix area, **520-791-2722** if you live in the Tucson area. Outside Phoenix and Tucson call toll free **1-877-600-2722** or **1-877-877-6226** for TDD for hearing impaired *(para los sordos).*

FAILURE TO RETURN, SIGN AND COMPLETE BOTH SIDES OF THIS FORM COULD RESULT IN DENIAL OF BENEFITS

Please enter your social security number in the space provided on the reverse of this form to avoid any potential delay in the payment of benefits. This form must be received or postmarked no later than seven days after the mailing date shown above. Mail or fax to the address or fax number shown above.

Exceptions to the requirement to record work search contacts:

1) If you are a member in good standing of a union with a hiring hall and you are on the out of work list, complete and sign the reverse side of this form. Be sure to include the name and local number of the union as well as the phone number in the appropriate line and mail to address above.
2) If you have returned to full time work prior to the date above and will not file any further weekly claims, provide the following information:

   Name and address of employer _____

   Date returned to work _____

Sign the reverse side of this form and mail to the address above.

ENTER THE FIVE MOST RECENT ENTRIES FROM YOUR WORK SEARCH LOG

DATE	NAME AND ADDRESS OF EMPLOYER	PHONE	TYPE OF CONTACT	RESULTS/COMMENTS

IF YOU HAVE NOT BEEN LOOKING FOR WORK PLEASE PROVIDE DETAILED REASON: _____

Equal Opportunity Employer/Program ● Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity, because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the UI Call Center.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

ELIGIBILITY REVIEW QUESTIONNAIRE

Please complete this form as instructed.

CLAIMANT'S NAME *(Last, First, M.I.)* | SOC. SEC. NO.

1. INDICATE THE KIND(S) OF WORK YOU ARE TRYING TO FIND AND LENGTH OF EXPERIENCE IN EACH

YRS. MOS. | YRS. MOS. | YRS. MOS.

2. INDICATE THE KIND OF WORK YOU DID FOR YOUR LAST FULL-TIME EMPLOYER | RATE OF PAY $ ☐ HR. ☐ WK. ☐ MO. | LENGTH OF EMPLOYMENT

3. LOWEST RATE OF PAY YOU ARE NOW WILLING TO ACCEPT FOR A NEW JOB
$ per

4. INDICATE THE SHIFT(S) YOU ARE WILLING AND ABLE TO WORK
☐ Day Shift ☐ Afternoon Shift ☐ Night Shift

5. INDICATE THE DAYS YOU ARE WILLING AND ABLE TO WORK
☐ Sun. ☐ Mon. ☐ Tue. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat.

6. INDICATE THE NUMBER OF MILES YOU ARE WILLING AND ABLE TO TRAVEL TO WORK

7. INDICATE THE MEANS OF TRANSPORTATION YOU NOW USE
☐ Own car ☐ Bus ☐ Walk ☐ Bicycle ☐ Other *(Specify)*

	Yes	No	
8.	☐	☐	Do you have children or anyone else requiring care which would prevent you from accepting full-time work? If yes: PLEASE EXPLAIN
9.	☐	☐	Do you have a definite date to return to work with an employer? If yes: DATE | EMPLOYER'S NAME AND ADDRESS *(No., Street, City, State, ZIP)*
10. a.	☐	☐	Do you obtain work only through a hiring hall of a union? If yes:
b.	☐	☐	Are you on the out-of-work list? If yes: MOST RECENT DATE SIGNED ONTO THE LIST | UNION NAME | LOCAL NO.
11.	☐	☐	Do you need a special license to do your work, e.g., chauffeur, barber, nurse, real estate? If yes: DATE YOUR LICENSE EXPIRES | TYPE OF LICENSE
12.	☐	☐	Are you or have you been in business of any kind, a corporate officer, working on a commission basis, doing any odd jobs, or working part-time or full time? If yes: PLEASE EXPLAIN
13.	☐	☐	Are you attending or planning to attend school, or have you attended school in the past six months? If yes: NAME OF SCHOOL | DAYS/HOURS OF ATTENDANCE
14.	☐	☐	Are you receiving or have you applied for retirement or any other type of pension/annuity (other than Social Security)? If yes: NAME/TYPE | AMOUNT $ ☐ Wk. ☐ Mo.
15.	☐	☐	Do you have a physical condition or handicap which would limit your ability to work full-time now? If yes: PLEASE EXPLAIN
16.	☐	☐	Is there any reason you could not accept full-time work now? If yes: PLEASE EXPLAIN

CERTIFICATION: I have answered these questions for the purpose of obtaining Unemployment Insurance benefits, knowing that the law provides penalties for making false statements. I understand that I am to review this form for each week I claim benefits and if the information which I have provided changes, I must report these changes to my local Unemployment Insurance office immediately.

CLAIMANT'S SIGNATURE	DATE	DEPUTY'S SIGNATURE	DATE

Empleador/Programa con Igualdad de Oportunidades ● Bajo los Títulos VI y VII de la Ley de Estadounidenses con Incapacidades del año 1990 (Americans with Disabilities Act: ADA) y la Ley de Derechos Civiles del año 1964, Sección 504 de la Ley de Rehabilitación de 1973, y la Ley de Discriminación a Edad de 1975, el Departamento prohíbe discriminar en los programas, entradas, servicios, actividades o el empleo basado en raza, color de piel, religión, sexo, origen nacional, edad, e incapacidad. El Departamento tiene que hacer arreglos razonables para permitir a una persona con una incapacidad participar en un programa, servicio o actividad. Esto significa, por ejemplo, que si es necesario el Departamento debe proporcionar intérpretes de lenguaje en señas para personas sordas, un establecimiento accesible para sillas de ruedas, o materiales con letras grandes. También significa que el Departamento tomará cualquier otra medida razonable que le permita a usted entender y participar en un programa o una actividad, incluso efectuar cambios razonables en la actividad. Si usted cree que su incapacidad le impredirá entender o participar en un programa o actividad, por favor infórmenos lo antes posible qué necesita para acomodar su incapacidad. Para obtener este documento en otro formato u obtener información adicional sobre esta política, comuníquese con los centros para llamadas.